



South Dakota Board of Nursing
South Dakota Department of Health
4305 South Louise Avenue Suite 201
Sioux Falls SD 57106-3115
(605) 362-2760 Fax: (605) 362-2768

Application to Request Equivalency of Education for 75-Hour Nurse Aide Training

Nursing Students may request to meet the 75-hour Nurse Aide training program requirement by equivalency of education pursuant to ARSD 44:74:02:16. South Dakota Board of Nursing (SDBON) grants approval for students actively enrolled in Board-approved nursing education programs as students are prepared using curricula that include nursing theory and clinical instruction which meet the 75-hour Nurse Aide training program content required in ARSD 44:74:02:15.

SDBON will send written notice as to whether the student: (1) is *granted* approval to waive the Nurse Aide training program and is eligible to schedule the written and manual competency evaluations for nurse aides through the South Dakota Healthcare Association; or (2) is *denied* approval to waive the Nurse Aide training program and why.

RNs and LPNs do not need to complete Nurse Aide training or evaluations to be placed on the South Dakota CNA registry.

Student/Nurse Name: _____

Address: _____

City ST Zip: _____

Date of Birth: _____ SSN: _____

Telephone: _____ Fax: _____

Email: _____

Director of Nursing or Nursing Faculty Member must attest for the nursing student that an approval for waiver of Nurse Aide training for this individual is appropriate. Complete and sign:

Nursing Facility: _____

Name / Title of DON or Faculty Member: _____

Address: _____

City ST Zip: _____

Telephone: _____ Fax: _____

Email: _____

DON or Nursing Faculty Signature: _____ **Date:** _____

Submit with this application:

☐ Copy of student's school transcript, grade report, or other school documentation supporting request
The student must have completed a nursing course(s) on fundamental nursing concepts and skills

OR

☐ Provide RN/LPN license number and state/jurisdiction of that license (may be current or inactive/expired license)

Number: _____ State: _____ Expiration Date: _____

(Note: South Dakota Board of Nursing will verify the licensure status of the nurse; if a nurse has had any disciplinary action, BON staff will review and determine whether or not the individual may be placed on the South Dakota Nurse Aide Registry.)

Applicant Signature: _____ **Date:** _____

Send this completed application and supporting documentation to the South Dakota Board of Nursing.

This section to be completed by the South Dakota Board of Nursing

Date Application Received:

Date Application Denied:

Date Approved:

Reason for Denial:

Board Representative:

Date Notice Sent to Student and / or Nursing Facility: